COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
CHANGE IN SHARE-OF-COST

(COUNTY STAMP)

Case name: _____
Case number: _____
District: _____
Change in share-of-cost for: _____
_____
_____
(Names)

Your share-of-cost has been changed to $ _____ per month beginning _____ because:

Your new share-of-cost was determined as follows:

Monthly Gross Income	$_____
Monthly Net Nonexempt Income	$_____
Maintenance Need	$_____
Excess Income/Share-of-Cost	$_____

The regulations which require this action are California Code of Regulations, Title 17, Section(s): 1498, et seq.

TAKE YOUR PLASTIC CARD TO YOUR MEDICAL PROVIDER WHENEVER YOU NEED CARE. DO NOT THROW AWAY YOUR PLASTIC ID CARD.

If you have questions about this action or if there are more facts about your conditions which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you.

Eligibility Worker _____ Phone _____ Date _____

PLEASE READ THE REVERSE SIDE OF THIS NOTICE